EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
REPORT OF THE WORK GROUP ON PHYSICAL RESTRAINT OF CHILDREN
DECEMBER 22, 1998

INTRODUCTION

On April 29, 1998, a 16 year-old client of the Department of Social Services residing at the Wayside Carriage House in Marlboro died while being physically restrained by staff. The State Medical Examiner's Office determined the cause of death was blunt trauma to the neck. The Department of Social Services and the Office of Child Care Services conducted an investigation regarding the specific incident. The Middlesex District Attorney's Office conducted an investigation and also requested a judicial inquest into the death. Health and Human Services Secretary William D. O'Leary met with the commissioners of the mental health, mental retardation, social services, childcare services and youth services departments to review state regulations and agency policies. It was agreed that client safety is paramount in residential programs and that certain holds, during a restraint or at any other time, are not consistent with providing for client safety as outlined in the regulations. Commissioners were directed to ensure current policy and practices reflect these guidelines.

Additionally, Secretary O'Leary initiated a review of the use of emergency restraints in residential programs serving children in the care of human service agencies. As part of this review, a multi-discipline work group of experienced professionals from the areas of law enforcement, the medical profession, the human service provider system, and policy and training was convened to make recommendations to the Secretary regarding restraint approaches that promote the safety of clients, recognize the diversity of the populations served and provide constructive guidelines to agencies regarding policy and training issues.

To inform the Work Group's process, the following activities were undertaken:

- A team comprised of knowledgeable staff from the Executive Office of Health and Human Services and its agencies headed by the Office of Child Care Services conducted a series of site visits to review restraint procedures utilized in human service programs.
- The Child Welfare League of America (CWLA) was engaged to conduct a survey of twelve states regarding the statutory, regulatory and policy guidelines on restraints. The states' guidelines in more than twenty topic areas were comparatively reviewed in a document prepared by CWLA's National Center for Consultation and Professional Development.

The Work Group found the issues regarding physical restraint compelling, complicated and almost devoid of any standard of care. Service providers have attempted to devise safe and effective intervention strategies for children, most often adolescents, acting dangerously. While the survey of states provided by the Child Welfare League revealed Massachusetts to be a leader when it comes to regulatory oversight, there is room for major improvement in the level of guidance provided by our oversight agencies.

DEFINITIONS

Generally, the behavior management process in potentially dangerous situations consists of the following steps:

a) De-escalation - attempts to verbally de-escalate a volatile situation and avoid physical intervention;
b) Physical escort - touching or holding of the hand, wrist, arm or shoulder for the purpose of moving a non-cooperative child from one location to another;
c) Physical take-down- technique utilized to bring a child engaged in dangerous behavior to a prone or sitting position;
d) Physical restraint - a behavior management technique involving the use of physical holding as a means of restricting the client's freedom of movement;
e) Monitoring – observation of physical and behavioral responses of child for signs of distress while being restrained;
f) Release - release of the child from a restraint hold upon determination that child will not continue to engage in dangerous behavior;
g) Follow-up – review of each restraint with involved staff as part of feedback/improvement process.

BASIC TENETS

In residential programs for children, the decision-making process involving potentially dangerous situations should always make safety the first priority. There are inherent dangers in any physical take-down or restraint. This fact should weigh heavily in the restraint decision which also requires consideration of group and staff safety. Staff should always first attempt to defuse the situation, with interventions designed to calm the child, before resorting to physical take-down or restraint for the safety of the child or others. The decision to restrain a child must always be based upon a safety objective and it should only occur after less intrusive interventions have failed to succeed. The physical and behavioral responses of the child being restrained must be constantly monitored for indications of physical distress. The child should be gradually released from the restraint as soon as it appears safe to do so.

Regulations, policies, licensing standards, contract provisions, program monitoring, staff training and supervision and other quality assurance activities should be devised to promote these objectives.

ANALYSES AND RECOMMENDATIONS

The working group organized its review into the areas of:

- Prevention, the use of alternatives to attempt to de-escalate a potentially dangerous situation and avoid the need for a physical restraint;
- Authorization, the demonstrable justification needed to employ a physical restraint;
- Safety, the physical interventions and precautionary measures to be taken;
- Accountability, the ongoing review, information sharing, and improvement processes; and
- Training, the teaching of restraint avoidance and application techniques.

In each of the topic areas. the findings of the CWLA survey and the regulations operative in Massachusetts are outlined.

The Working Group's analyses and recommendations. which are highlighted in bold. follow.

PREVENTION

CWLA Survey – Only two of the states' regulations go as far as to state that less intrusive alternatives should be explored prior to employing a physical restraint.

Massachusetts Regulations – Require staff to be trained on the use of alternatives to restraint. No requirement that alternatives must be attempted first. just that the form of physical intervention be the least intrusive means necessary.

Anytime a physical intervention is employed, there is a risk of injury. Therefore, **agency regulations should mandate the utilization of alternative interventions thereby minimizing the need to employ a physical restraint.**

In reviewing the use of restraints, it was found that those agencies that trained its staff thoroughly in understanding adolescent behavior and effective verbal interventions were likely to have fewer restraints due to their ability to de-escalate a potentially violent situation by quickly resolving incidents. Effective training methods identify the various stages of escalating behavior and the appropriate response to be utilized to de-escalate the situation. For example. when the child is demonstrating anxiety by pacing, and being verbally aggressive, staff should be trained to be empathetic. If the child becomes defensive and is exhibiting less control. staff should be trained to set behavioral limits.

Important to the prevention of restraints is the relationship between staff and residents and the capacity for residents to feel safe within the program. Additionally. **systems should be modified in order to ensure that informational histories relevant to each individual are available at intake**. This information should inform staff about prior effective and ineffective de-escalation methods used with the child which will help minimize the need for restraint. **Individual recommendations with regard to behavioral needs and management should be part of each case plan.**

Staff should also be trained on alternatives to unnecessary confrontational approaches and power struggles. For example, it may be more effective to remove others residents from a room rather than using a physical intervention to remove a refusing child and thereby exacerbating the situation.

Effective de-escalation methods should be regularly taught to childcare workers across the state in order to ensure that skill levels in this area are consistently high.
While violent and dangerous outbursts can suddenly occur, well-trained staff can predict most of these incidents and utilize prevention techniques with success.

AUTHORIZATION

CWLA Survey – Six of the states' regulations only allow physical restraint in order to prevent harm to the child or others. Two of these six states also authorize restraint to prevent property damage and one state also allows restraint to prevent serious disruption to a program. Four states did not specify a threshold or left it to each facility to decide.

Massachusetts Regulations – Allows use of physical restraint in cases of emergency where actual or serious threat of violence to child, others or property.

It is well settled that in order to protect an individual from being harmed or harming others, the power of the state can be invoked in certain circumstances to restrain liberty (civil commitment) or remove custody (care and protection). It therefore follows that whenever a state agency has legal custody of a child, the state has both the responsibility to protect the child and others from him/her as well as the authority to take action in order to prevent harm. The state then has the authority to delegate that authority to anyone with whom it contracts to take responsibility for the child.

The Working Group recommends **that physical intervention be employed when there is a demonstrable danger to the child him/herself, or others as a result of actions by the child and no other intervention has been or is likely to be effective to avert the danger. A written incident report should be completed after every restraint which would include the justification for the restraint.**

Many decisions regarding making determinations as to whether this threshold has been met, involve weighing a number of different factors which may include the age of the child, past history, parental input, program philosophy, etc. It is a balance between the risk associated with employing a physical intervention and the risk associated with not employing a physical intervention where there may be future harm to the child or others.

In weighing these risks the following must be considered:

A clear duty to protect where there is immediate risk of harm to self or others
When a child is at risk of hurting himself or assaulting others, and de-escalation interventions have been unsuccessful, it is reasonable to employ a physical restraint.

In discussions with agency and provider staff, it was apparent that there are inconsistent practices regarding efforts to stop a youth from running from a program. In those cases where the state agency has legal custody, there is a duty to protect the child. In these situations, the state has an obligation to ensure the safety of the youth and the community by preventing the youth from the leaving the program. The area where there is less clarity are those circumstances where a program is given responsibility to care for the child with complete legal custody remaining with the parent. It would seem reasonable to assume that the transfer of some form of physical custody to the program, and with it a level of responsibility to protect the child from harm, requires a similar transfer of authority to take the action necessary to prevent the child from harming himself or others. **It would seem prudent in these circumstances for the program to seek parental consent, upon the child's entry into the program, to take the measures necessary to prevent harm.**

Maintain Program Safety

At times, acting out behavior by a child may threaten the ability of staff to operate the program safely. In these circumstances, physical intervention may be required if it can be documented that alternatives were unsuccessfully employed and program safety is compromised. As mentioned previously, programs should avoid making and enforcing rules that lead to needless power struggles which may result in unnecessary physical restraints, i.e., if a child refuses to comply with a rule that requires shoes to be removed, staff must be able to clearly demonstrate that failure to remove shoes would compromise personal or program safety and that there are no other alternatives. **If minor infractions regularly result in restraints, then the roles of staff, policies and rules should be reviewed by the program. Restraints should never be employed for punishment purposes or for the convenience of the program.**

It is the responsibility of each program at the implementation level to be absolutely clear as to the threshold required to be met in order to employ a physical restraint and what factors are to be considered by staff in making this determination. Lack of consistency in this area can be detrimental to the safe operation of the program. The threshold should also be consistent from program to program, whenever possible.

SAFETY

CWLA Survey – None of the states' regulations authorize or prohibit specific restraint techniques. One state's regulations prohibit restraints that apply pressure to the child's respiratory system or to cause pain, and prone restraints on pregnant females. Another state prohibits any action that causes pain or restricts the circulation or respiration of the child.

Massachusetts Regulations – No specific prohibitions currently exist in regulatory form. Agency prohibitions are contained in Secretary O'Leary's May, 1998 memorandum.

Recognizing that there are risks associated with all physical interventions, some putting the limbs at risk of injury while some others put the child's air passages at risk of being compromised, the **Working Group recommends that the agencies' prohibitions on choke holds, headlocks, full nelsons, half-nelsons, hog-tying and the use of pressure points to inflict pain, continue to be adhered to. Included are techniques for which it is foreseeable that application could result in a prohibited hold.**

The site visits and survey of licensed children's residential programs conducted by the agencies' team revealed the existence of a wide array of restraint methods. There were fifteen individually recognized methods utilized with over half of the programs using one of three of them. Many programs modified a recognized method to meet program/population needs and some other programs reported that they used a method developed on their own.

This wide array of methods yielded variety in the different aspects of the restraint process. In the physical control phase, most programs employed a method of physically escorting a child from one place to another utilizing some form of arm and/or shoulder hold. Some programs chose to not use any form of escort citing it as likely to result in further escalation of the situation. Most restraint methods use some form of "take down". Some methods call for the child to be lowered

to the floor into a sitting position, some result in the child being lowered to the floor into a prone position facing forward, while a couple of methods call for the child to be lowered backwards.

During the aspect of the restraint method where the child is most immobilized, it is often accomplished while the child is on the floor. However, the method used most often is designed as a standing hold. Those designed for the floor vary in how they are to be performed. Most have the child facing the floor, with some designed for the child to either be on his/her side or back.

Medical experts should be consulted on safety concerns related to individual restraint methods, especially those which call for staff to be applying pressure to the child's back, thereby giving rise to the possibility of the diaphragm being compressed. Research indicates that any restraint method which impedes expansion of the chest can lead to positional asphyxia. High risk conditions, such as, obesity and cocaine detoxification, are additional risk factors associated with diaphragm compression.

The list of prohibited holds is comprised mainly of those which could involve the neck area which could lead to constricting air passageways or blood flow to the brain.
Staff should also be mindful of other injury risks associated with physical restraint such as joint and bone injuries of the limbs. According to the reported data the rate of serious injuries to children involved in restraints is very low, yet the need to restrain is still an indication of system failure if all known methods of prevention had not been utilized.

Any medical condition or physical infirmity of the child should be discussed, with medical personnel if necessary, upon entry into the program in order to assess the need for an individualized restraint method. If an individualized method is needed, it should be made part of the case plan together with the particular medical indications that staff must be on the look out for whenever the child is restrained. A system should be in place to ensure this information is communicated to all staff.

All restraints should include provision for the physical condition of the child to be constantly monitored. This should include, at a minimum, the breathing and color of the child. **Any distress being exhibited by a child should be treated as a medical rather than behavioral issue and medical assistance should be obtained immediately.** Staff should be trained on any other medical indications that they should watch for whenever a child is being restrained, i.e., child either quieting or becoming increasingly agitated are both potential indicators of serious physical problems.

Policies and practice should reflect the goal that the length of the restraint should be as short as possible. The child should be released at the first indication that it is safe to do so. Programs should be discouraged from delaying release until the child verbally contracts for his and other's safety.

Consideration should be given to setting a maximum time for a restraint depending upon the child's age, physical limitations, etc. Specific time intervals should be set for staff to be rotated during the course of a restraint.

Programs should give special consideration to the children's age, size, physical and mental infirmities, etc., in choosing the restraint method(s).

The Inter-Agency Restraint Coordination Group (described later in the Accountability section) **needs to conduct additional medical and data related reviews of the various physical restraint techniques in order to better inform residential programs of best practices and problematic approaches.**

ACCOUNTABILITY

CWLA Survey – Only five of the states require the reporting of restraints. These same states also require the reporting of serious injuries. One state requires follow-up in the following circumstances: multiple restraints of same child. multiple restraints by same staff and serious injury.

Massachusetts Regulations – No requirement for reporting restraints to oversight agency. but an incident report must be inserted in the client's record. Any restraint resulting in serious injury must be reported.

A consistent comprehensive review of restraints from the program level to the agency level will ensure that both the numbers of restraints and injuries resulting from restraints are as small as possible. **Therefore points of accountability should be developed at the program and agency levels, which emphasize the importance of data review, and the need for change based upon the data. The program should be required to designate a point person on behavior management who would be responsible for: oversight and documentation of training at the program; ensuring that restraints are only being employed when necessary; ensuring that the restraint method is being implemented correctly; and collecting and analyzing restraint and injury data and reporting it on a quarterly basis to oversight agencies. Each provider agency should form a safety committee, comprised of oversight staff and program direct care and clinical staff, to regularly review restraint data and client and staff safety information.**

A state agency point person would be responsible for reviewing the numbers of restraints and injuries by program and ensuring that regular oversight of restraints in the programs is occurring. The agencies' point people would collectively form an interagency restraint coordination group chaired by OCCS which would be responsible for: keeping up to date on restraint related issues through regular literature review and conferences; providing an annual training conference to demonstrate the various restraint techniques and describe the advantages and disadvantages of each, the conference would also offer the opportunity to keep the field updated on the latest information available on restraint prevention and application; and ongoing communication with programs on technical assistance issues including publishing a newsletter.

There should be a focus on the data as to when most restraints are occurring. Restraints seem to happen more often during non-programmed time and when there is movement from one activity to another. **There is a clear need to process the use of restraints as part of a continuous staff feedback loop. Data should be analyzed regarding the frequency or scarcity of restraints involving particular staff, during particular shifts and involving the same child(ren). Multiple restraints of the same child should result in a formal review of the**

appropriateness of the placement for the child. Staff who are frequently involved in restraints should be evaluated as to their need for further training and supervision.

TRAINING

CWLA Survey – Eight states require training in behavior management and or de-escalation techniques. Six states require annual re-training in this area. Though four states require a minimum number of hours of total training, only one state sets a specific minimum number of hours required for restraint and de-escalation techniques.

Massachusetts Regulations – Requires orientation in behavior management including restraints. Full time staff are required to receive a minimum of 24 hours of training annually. There is no requirement for the annual training to include restraints.

The minimum number of hours required for training in this area should be 16 hours upon hire with annual refresher training of 8 hours with written pre and post tests. The training should include: needs and behaviors of the population served; relationship building; prevention of restraint; de-escalation methods; "power struggles"; thresholds for restraints; physiology; monitoring for physical signs of distress and obtaining medical assistance when needed; legal issues; "positional asphyxia"; escape and evasion techniques; time-limits; process for obtaining approval for a longer restraint; procedures to follow when a restraint goes awry; documentation; de-briefing of child and staff; investigation of injuries and complaints. Training should also include role-playing to allow staff to demonstrate an understanding of and ability to use the de-escalation techniques taught. All holds used for restraint must be taught, with practice time provided, so as to allow staff to be able to demonstrate proficiency with each hold. No staff member should be allowed to be involved in a restraint until he/she has successfully completed the training.

Trainers must be currently certified (or, otherwise determined to be proficient by OCCS if no certification process is available for the technique) **in the method that they teach. After demonstration and review of the restraint technique and de-escalation methods to be utilized, OCCS shall, if appropriate, approve the training curriculum/lesson plans.**

Discussions and activities at regular staff meetings and debriefings should be utilized to reinforce and enhance the skills of staff in these areas.

At least one staff per shift should be certified in both CPR and First Aid. Each direct care staff should be certified in CPR and First Aid within six months of hire. Staff should be re-certified within the timelines specified by the certifying authority.

CONCLUSION

The Working Group found that enhanced safety and effectiveness could be achieved through focused collaboration among state agencies, providers and program staff regarding restraint training and data. The development of a blueprint outlining prohibitions, best practices and mechanisms that will ensure consistent review will assist the system to become safer and more effective.

IMPLEMENTATION STEPS

- Inter-Agency Restraint Coordination Group established immediately (chaired by OCCS and including DSS, DMH, DYS and a provider agency representative) to accomplish the following:
  - Formulate consistent definitions for use throughout system by 1-15-99
  - Obtain further medical review of restraint techniques and establish best practices and problematic approaches by 2-28-99
  - Design standards for OCCS use in approval of pre-service and refresher training curriculum and lesson plans by 3-31-99
  - Select training topics, including: demonstration of various restraint and de-escalation methods, review of agency policies and regulations on authorization, accountability and training. Design curriculum and conduct first annual training conference for all designated program staff as well as provider and state oversight staff by 4-30-99

- OCCS issues interim policy requiring programs to submit, within 30 days, details of current methods of prevention and restraint technique used as well as the program's training curriculum and schedule by 12-22-98

- State and provider programs required to designate a staff member as restraint coordinator by 1-15-99
- State agencies convene meetings to develop agency policies with guidance from interagency working group by 1-31-99
- State agencies issue policies on restraint by 4-30-99
- OCCS promulgates regulations by 4-30-99